State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: July 17, 2012

MMCD POLICY LETTER 12-004
SUPERSEDES POLICY LETTER 11-007

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: REQUIREMENTS FOR HEALTH RISK ASSESSMENT OF MEDI-CAL SENIORS AND PERSONS WITH DISABILITIES

PURPOSE:
The Department of Health Care Services (DHCS) is issuing this Policy Letter (PL) to supersede PL 11-007, Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities (SPDs). While PL 11-007 was addressed to Two-Plan Model (TPM) and Geographic Managed Care (GMC) Medi-Cal managed care health plans (Plans), this PL also applies to County Organized Health Systems (COHS) Plans, which are no longer exempt from this policy (Standard Terms & Conditions [STCs] of the 1115 Waiver, Item 89) and must implement it by November 1, 2012.

Along with its predecessors, this PL provides a definition for "higher-risk" beneficiaries, which for purposes of the risk stratification process means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they are not contacted by the Plans within 45 calendar days of enrollment.

PL 11-007 provided Plans with the information necessary to implement the health risk assessment (HRA) of Medi-Cal-only SPDs and to develop the risk stratification and risk assessment survey tools that must be submitted to DHCS for approval, as required by Welfare & Institutions (W&I) Code section (§) 14182 (Senate Bill 208, Chapter 714, Statutes of 2010).

BACKGROUND:
W&I Code §14182 permits DHCS to enroll SPDs into Plans on a mandatory basis and implement the statute's requirements through a PL. The Centers for Medicare & Medicaid Services (CMS) approved California's Section 1115 Waiver, "A Bridge to Reform" (1115 Waiver), effective November 1, 2010, which included federal approval to enroll SPD beneficiaries on a mandatory basis into Plans.

On June 1, 2011, DHCS began mandatory enrollment of the Medi-Cal-only SPD population into Plans in counties where their enrollment had previously been voluntary. Mandatory enrollment of this population was phased in over a 12 month period. As each SPD was enrolled into a Plan, the Plan evaluated the SPD's health status by applying a health risk stratification mechanism or algorithm and performing a health risk assessment (HRA) survey within statutorily required timeframes.

Plans operating under the COHS model have always enrolled all Medi-Cal beneficiaries, including SPDs. As of November 1, 2012, COHS Plans must implement the same health assessment standards and practices for SPDs that have been required of TPM and GMC Plans.

DISCUSSION:
W&I Code §14182 requires Plans to develop and submit for DHCS review and approval two tools or processes to identify the relative health risk of each member. These tools or processes will be used by Plans to develop individualized care management plans for their SPD members who have been determined to be at higher-risk of requiring costly and complex healthcare services. The first, a risk stratification mechanism or algorithm, will be applied by Plans using member-specific Medi-Cal fee-for-service (FFS) utilization data to identify those members with higher-risk and more complex healthcare needs. The second tool or process, an HRA survey, shall be used to assess each SPD member's current health risk within 45 days of enrollment for those identified by the risk stratification method or algorithm as higher-risk and within 105 days of enrollment for those identified as lower-risk.

The STCs of the 1115 Waiver approved by CMS require DHCS to provide detailed information about the HRA process and ensure that specified assessment components are included in each Plan's assessment method. These components provide for comparability and standardization of elements among all Plans. Additionally, DHCS must monitor and report Plan activities and develop Plan performance measures specific to the SPD population. Plans must report specified information and statistics related to the HRAs for these purposes.

Plan contract language will be added to include these new requirements. This PL will be referenced in Plan contracts and will provide the detail necessary to implement and comply with these new requirements.

POLICY:
In accordance with W&I Code §14182 and the STCs, Plans shall develop and submit the following by March 1, 2011, for TPM and GMC Plans, and by **August 1, 2012, for COHS Plans**, or three months prior to implementation, and DHCS will review within one month of submission:

A. A risk stratification mechanism or algorithm designed for the purpose of identifying newly-enrolled SPD members who have higher-risk and more complex health needs, and those who are at lower-risk, within 44 calendar days of enrollment. "Higher-risk" for risk stratification purposes means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not receive their initial contact by the Plan within 45 calendar days of enrollment. The higher-risk individuals who should be identified from the FFS utilization data and the self-assessment questionnaires include but are not limited to beneficiaries who:

- Have been on oxygen within the past 90 days.
- Are residing in an acute hospital setting.
- Have been hospitalized within the last 90 days, or have had three-or-more hospitalizations within the past year.
- Have had three-or-more emergency room (ER) visits in the past year in combination with other evidence of high-utilization of services (e.g., multiple prescriptions consistent with the diagnoses of chronic diseases).
- Have a behavioral health diagnosis or developmental disability in addition to one-or-more chronic medical diagnoses or a social circumstance of concern, e.g., homelessness.
- Have End-Stage Renal Disease (ESRD), Acquired Immunodeficiency Syndrome (AIDS), and/or a recent organ transplant.
- Have cancer, and are currently being treated.
- Are pregnant.
- Have been prescribed anti-psychotic medication within the past 90 days.
- Have been prescribed 15 or more prescriptions in the past 90 days.
- Have a self-report of a deteriorating condition.
- Have other conditions as determined by the Plan, based on local resources.

The submission must include:

1. A process for incorporating stakeholder and consumer input into development of the mechanism or algorithm.
2. A process for use of member-specific information including their historical Medi-Cal FFS utilization data provided by DHCS electronically at the time of enrollment. This data may include, but is not limited to, outpatient, inpatient, emergency department, pharmacy, and ancillary services data for up to the most recent 12 months.
3. A process for use of the information obtained from the completed Health Information Form/Medical Evaluation Tool (HIF/MET), a member self-assessment of health that is electronically provided to TPM and GMC Plans by DHCS's enrollment broker at the time new members enroll.
   COHS Plans must download the HIF/MET from DHCS's website at www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/MET/MET_MU_0003754_ENG_1010.pdf, and distribute it to COHS members at the time they enroll, and gather data from the HIF/METs that are returned. A hardcopy of the HIF/MET is enclosed with this PL.
4. A process that tests the stratification mechanism or algorithm by using Plan utilization data to stratify current voluntarily enrolled SPD members into higher and lower-risk groups.

B. A risk-assessment survey tool that shall be used to comprehensively assess a member's current health risk within 45 calendar days of enrollment for those identified by the risk-stratification mechanism or algorithm as higher-risk and within 105 calendar days of enrollment for those identified at lower-risk for the purpose of developing individualized care management plans for those SPDs identified as higher-risk. "Higher-risk" for risk-assessment purposes means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan. The submission must include:

1. A process for incorporating stakeholder and consumer input into development of the tool or process.
2. A process for contacting members within the required assessment timeframes that will include repeated efforts (letter followed by at least two phone calls) to contact each member.
3. A process for stratifying members into at least two groups, those needing basic and those needing complex care management.

4. A process describing how the Plan will identify medical care needs, including primary care, specialty care, durable medical equipment, medications, and other needs and develop an individual care-management and care-coordination plan as needed.
5. A process for identification of referrals needed to appropriate community resources and other agencies for services outside the scope of responsibility of the Plan, including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities.
6. A process to identify the need for including appropriate involvement of caregivers.
7. A process to identify the need for facilitating timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access.
8. A process to identify the need for facilitating communication among the member's health care providers, including mental health and substance abuse providers when appropriate.
9. A process to identify the need for providing other activities or services needed to assist members in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.
10. A process to identify the need for coordination of care across all settings including those outside the provider network and to ensure that discharge planning is provided to members who are admitted to a hospital or institution.
11. A process for determining timeframes for re-contact or reassessment at least annually and, if necessary, the circumstances or conditions that require redetermination of risk-level.

C. Plan Reporting Requirements

Beginning November 15, 2011, for TPM and GMC Plans and **May 15, 2013, for COHS Plans, and quarterly thereafter,** Plans shall report to MMCD 135 days after the end of each quarter, at a minimum:

1. The number of newly-enrolled SPD members during the quarter who have been determined to be at higher-risk and lower-risk by means of the risk-stratification mechanism or algorithm.

2. The number of newly-enrolled SPD members during the quarter in each risk category who were successfully contacted (Plan received phone or mailed response) during the quarter and by what method.
3. The number of newly-enrolled SPD members during the quarter who were successfully contacted and who completed the risk assessment survey (answered all questions) and the number who declined the risk-assessment survey.
4. The number of newly-enrolled SPD members during the quarter who completed the risk-assessment survey and who were then determined to be in a different risk category (higher-or-lower) than was established for those members by the plan during the risk-stratification process.

This data must be submitted in the format as outlined in the most recent Plan reporting instructions document and be emailed to SPDMonitoring@dhcs.ca.gov. The Plan reporting instructions document will be revised over time and emailed to the Plans' main contacts.

If you have any questions regarding the requirements of this PL, please contact your MMCD contract manager. We look forward to supporting Plans in their implementation of the risk-stratification and assessment processes for the new mandatory enrolled Medi-Cal-only SPDs.

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Attachment

Health Information Form

1010

DHCS

You are receiving this form because you are eligible to enroll in a new Medi-Cal health plan. Your new plan will use this form to make sure you get needed care.

Please fill in the circle with black or blue pen for the answers that apply to you. Complete one form for each person in your family who is enrolling in a new Medi-Cal health plan.

If you have questions, please call Health Care Options, toll free at 1-800-430-4263 Monday through Friday, between 8:00 a.m. and 5:00 p.m. TDD/TTY users should dial 1-800-430-7077.

Please return completed form with your Medi-Cal Choice Form or mail separately to:

CA Department of Health Care Services
Health Care Options - PO Box 989009
West Sacramento, CA 95798-9850

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Date of birth:

Name of Person Completing Form: ____________________

1. Do you need to see a doctor within the next 60 days? ○ Yes ○ No
2. Do you take 3 or more prescription medicines each day? ○ Yes ○ No
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ○ Yes ○ No
4. Have you been to the emergency room two or more times in the last 12 months? ○ Yes ○ No
5. Have you been admitted to the hospital in the last 12 months? ○ Yes ○ No
6. Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last 6 months? ○ Yes ○ No
7. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ○ Yes ○ No
8. Do you have a condition that limits your activities or what you can do? ○ Yes ○ No
9. Are you pregnant? ○ Yes ○ No
   9a. If Yes, are you currently seeing a doctor for this pregnancy? ○ Yes ○ No
10. Do you see a doctor regularly for a chronic medical condition? ○ Yes ○ No

If Yes, fill in all that apply:

○ a. Asthma	○ b. Cancer	○ c. Cystic Fibrosis	○ d. Diabetes
○ e. Heart Problems	○ f. Hepatitis	○ g. High Blood Pressure	○ h. HIV or AIDS
○ i. Kidney Disease	○ j. Seizures	○ k. Sickle Cell Anemia	○ l. Tuberculosis
○ m. Other ____________			

When you become a health plan member, DHCS will send this information to your Medi-Cal health plan.

If you think you need to see a doctor before your Medi-Cal health plan contacts you, you should go to the doctor or hospital at that time.

I understand that this information will be disclosed to Health Care Options and my new plan.

Signature: ______________________ Date Signed: ___ - ___ - _____

If not signed by beneficiary, specify relationship: ☐ Parent of minor ☐ Guardian ☐ Other representative

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